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Follow-up actions to the recommendations of the International Conference on Population and Development

Monitoring of population programmes focusing on reproductive rights and reproductive health, with special reference to human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), as contained in the Programme of Action of the International Conference on Population and Development

Report of the Secretary-General

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Introduction

1. The present report on monitoring of population programmes has been prepared in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, endorsed by the Economic and Social Council in its resolution 1995/55 which identified reproductive rights and reproductive health, with special reference to human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), as the special topic for the thirty-fifth session of the Commission. The report focuses on country operational experiences and progress towards implementation of the Programme of Action of the International Conference on Population and Development[1] and the outcome of the twenty-first special session of the General Assembly for an overall review and appraisal of the implementation of the Programme of Action, especially as this relates to HIV/AIDS and family planning, maternal mortality, sexually transmitted infections (STIs), adolescent reproductive and sexual health, and gender equality and women's empowerment.

I. Reproductive rights and reproductive health

A. Concepts/framework

2. At the International Conference on Population and Development held in 1994 in Cairo, 179 countries approved by consensus a programme of action that acknowledged the integral and mutually reinforcing linkages between population and development. Rooted in fundamental principles of human rights, the International Conference on Population and Development took a holistic perspective, recognizing reproductive and sexual health as a component of primary health care and a means to improving quality of life. The twenty-first special session of the General Assembly showed progress in advancing the Conference goals and, at the meeting's conclusion, Governments called for intensified action in key areas for the further implementation of the Programme of Action: reproductive and sexual health, maternal mortality reduction, adolescents' reproductive health needs, prevention of HIV/AIDS, gender issues and education.[2] Reproductive rights have further been reaffirmed in a series of conferences in the 1990s, including the World Conference on Human Rights, the Fourth World Conference on Women and the World Summit for Social Development. In 1996, the Glen Cove Round Table was convened by the United Nations Population Fund (UNFPA), the Division for the Advancement of Women of the United Nations Secretariat, the Office of the United Nations High Commissioner for Human Rights, and the treaty bodies, and it was followed up in 2001 with another consultation.

3. Although the Programme of Action of the International Conference on Population and Development recognized the need "to prevent, reduce the incidence of, and provide treatment for, sexually transmitted infections (STIs), including HIV/AIDS" (para. 7.29), the twenty-first special session of the General Assembly further reinforced the focus on HIV/AIDS by calling upon Governments to increase efforts to integrate prevention and treatment of STIs, including HIV/AIDS, within "reproductive and sexual health programmes at the primary health care level" (see Assembly resolution S-21/2, annex, para. 68). In addition, the twenty-sixth special session of the Assembly on HIV/AIDS, held in June 2001, focused attention on the devastation caused by the pandemic and adopted a Declaration of Commitment on HIV/AIDS[3] to mount an expanded response to halt its advance.

B. Challenges and trends in meeting goals of the International Conference on Population and Development in reproductive rights and reproductive health

4. Despite many challenges facing the implementation of the Programme of Action of the International Conference on Population and Development and the outcome of the twenty-first special session of the General Assembly, substantial progress has been made towards a broader reproductive health approach with integration among different institutional structures, transformation of existing facilities, improvement of logistic systems and training to ensure appropriate and effective care. Thus, reproductive health is more often being addressed as a component of broad health programmes in countries undertaking health system and financing reforms.[4]

Many countries are abandoning traditional vertical programming in health by incorporating education and economic opportunity into policy and programmatic interventions. New partnerships are being formed that involve a range of stakeholders including non-governmental organizations, religious leaders and the clients themselves. Collectively these new strategies have helped to bring reproductive and sexual health issues to the forefront.[5]

5. A component of the broader reproductive health approach includes improving client satisfaction as a way of increasing the use of reproductive health services. Various projects in India, Nepal, the United Republic of Tanzania, Mauritania, Kyrgyzstan and Peru are aiming to do just that. These projects bring together clients and providers to define common goals and quality standards that are culturally relevant and appropriate to the local communities.[6] Owing to scarce resources, countries are engaging in health sector reform to increase cost-effectiveness and consumer satisfaction; and significantly, many countries, such as Mexico, the Philippines and South Africa, have adopted an essential services package that includes reproductive health.

6. The integration of family planning and maternal and child health under a common institutional umbrella has been the most common change. However, some countries such as India refer clients to delivery points where they can find higher-level services, such as STI treatment and emergency obstetric care.[7] A survey of health initiatives across the world reveals other encouraging improvements: Zambia's multisectoral and decentralized approach, involving civil society organizations, addressing gender issues and male involvement,[4] and the Women Health Volunteers Programme of the Islamic Republic of Iran, to promote the empowerment of women and community participation in reproductive health and family planning,[8] may be cited as examples.

II. HIV/AIDS

A. Magnitude of the problem and guiding principles

7. The spread of HIV/AIDS remains at epidemic proportions — far worse than was predicted even a decade ago. Alarmed by the accelerating epidemic and its global impact, the General Assembly convened a special session on HIV/AIDS to intensify international action and commitment as well as to mobilize resources. Adopted by acclamation by the Assembly, the Declaration of Commitment on HIV/AIDS recognizes the need to address HIV/AIDS by promoting respect for human rights and, in particular, the rights of those most vulnerable to infection, including women and children. The Declaration of Commitment on HIV/AIDS highlights the fundamental shift from addressing HIV/AIDS as a public-health dilemma to its acceptance as a global economic, social and development priority because of its threat to the well-being of future generations.[9] By adopting the Declaration, the international community has committed to increasing its response with specific targets and time frames in all critical areas including prevention, care, treatment and support.

8. Guiding principles of a comprehensive response to curbing the epidemic include: promoting the full realization of human rights, gender equality, and the involvement of people living with HIV/AIDS; ensuring national ownership and leadership; building national capacity; promoting a multisectoral approach; supporting broad-based social mobilization; and encouraging a massive scaling-up of efforts. The vision supported by the world's leaders is one in which all people infected and affected by HIV/AIDS live with respect, without stigma or discrimination, and in societies that understand the dimensions of the epidemic and are determined to change its course.[10]

B. Political commitment

9. A key lesson of the last decade is that strong political commitment is a common thread in all countries with positive experiences in responding to HIV/AIDS. Early in the onset of the disease, national leaders were reluctant to acknowledge the HIV threat owing to the fact that its causes and consequences required them to address difficult, sensitive and controversial subjects. Recently, owing to the seriousness of the epidemic, political leaders have begun to breach the wall of silence. Under the International Partnership against HIV/AIDS in Africa, a joint advocacy initiative was developed that enlisted African leaders' political commitment and financial support to combat the epidemic.[11] Prime ministers and finance ministers addressed AIDS as a key

development challenge during a meeting of the Caribbean Group for Cooperation in Economic Development organized by the World Bank.[12] Countries of the Commonwealth of Independent States (CIS) are developing a special declaration on the epidemic and are preparing a regional work plan to guide a coordinated response.[13] The Inter-Parliamentary Union adopted a resolution that calls on all parliamentarians to intensify their efforts to establish effective national and international AIDS policies and programmes.[14]

C. Prevention

10. Prevention should be the mainstay of any response in a country or community regardless of the magnitude of the epidemic.[10] HIV infection rates are stabilizing or decreasing in countries such as Uganda, Senegal, Thailand and the (northern) United Republic of Tanzania, precisely because focused and sustained prevention programmes have resulted in significantly safer behaviour.[11]

11. Education is needed to raise awareness, promote healthy lifestyles, and defuse stigma and discrimination associated with HIV/AIDS. Massive education campaigns in Brazil and Thailand were integral towards managing their epidemics.[15] Such campaigns can take many forms: in Namibia, interactive visual story telling of street sellers was utilized to increase knowledge about HIV and safe sex behaviour; and in Uganda, the Stepping Stones Project utilized participatory education focused on the needs of women to encourage condom use, decrease sexual partners and increase their ability to refuse unwanted sex.

12. The widespread availability and promotion of condoms, male and female, are integral to the prevention of HIV, as well as STIs which can increase the risk of HIV infection 10-fold.[11] Unfortunately, condoms are still not universally available. Despite this, Thailand's 100 per cent condom use programme helped hold an epidemic in check in the 1990s, while vigorous condom promotion appears to be paying off in Cambodia as well.[16] The use of individuals drawn from the community and trained in information, education and communication was key to the success of the condom social marketing programmes in several countries, among them, Haiti and Mozambique.[17] The Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) (UNAIDS) has provided start-up funds for condom social marketing programmes in Cuba, Myanmar and the Russian Federation.[18]

13. Reproductive and sexual health programmes, by providing needed information and services, serve as entry points for addressing the social and behavioural changes that are crucial to slowing the spread of HIV infection. Preventive measures including safer sexual behaviour can be discussed at this time, helping to ensure that HIV-negative individuals remain free from infection and that those infected learn to prevent further spread. The multi-centre trial in the United Republic of Tanzania, Kenya, and Trinidad and Tobago revealed that people who had undergone voluntary counselling and testing were found to have less unprotected intercourse outside their primary partnerships.[19] In Northern Thailand, participation in voluntary counselling and testing programmes decreased mother-to-child-transmission from 25 to 7.5 per cent.[20]

14. Young people are at the heart of the HIV/AIDS epidemic, since half of all new infections occur among them. On the positive side, however, they can adopt safe practices early and more easily than adults and have the potential to change the course of the epidemic. Peer education among young people in and out of schools in Brazil, Eastern Europe, India and the United Republic of Tanzania was effective in raising awareness about the risks of HIV infection and promoting behaviour change.[18] HIV prevention messages have also been relayed to young people through the media. A popular radio programme in Kenya and a television series in Nigeria utilized their formats to impart important information on HIV prevention and other issues of adolescent reproductive health.[11] Through family life education programmes, an estimated 66 school systems throughout the world have revised their curricula to incorporate HIV prevention education.[21] As part of a comprehensive multi-strategy approach, the concept of skills-based education developed as a means to give young people the ability to manage challenging situations and take control of their own health. Such programmes in Namibia, Viet Nam and Zimbabwe have imparted sexual health information and strengthened young people's communication, negotiation and decision-making skills.[22]

15. Many women and girls occupy subordinate positions in society, making it difficult or impossible

for them to protect themselves from HIV infection. They often are powerless to insist on fidelity, demand condom use, or refuse sex with their partner, and often lack the economic resources to remove themselves from relationships that put them at risk of HIV infection. Women also are biologically more vulnerable to HIV where the symptoms of STIs are often hidden, making them more difficult to diagnose than in men. Interventions in Brazil, Indonesia and the United Republic of Tanzania demonstrated how an emphasis on female-initiated and mediated communication with one's husband can result in reduced risk of STIs and HIV for women, and showed that women can learn to overcome their fear of a husband's refusal and anger. Peer education programmes in Bangladesh, Burkina Faso, Haiti and India provided women with effective responses to common male objections to condom use.[23] In south Kazakhstan and Almaty, volunteers provided contraceptives and information on HIV/AIDS and STIs to women of reproductive age, resulting in decreased abortion rate, increased contraception use and knowledge about contraception and STIs, including HIV/AIDS.[11]

16. In conflict situations, natural disasters and other crises, most of the displaced are women and the young. These situations increase their vulnerability to sexual violence and put them at risk of contracting HIV and other STIs. Such emergencies call for a quick response in the form of information campaigns and contraceptive supply. Refugees trained as peer educators in Zambia have helped Angolan, Congolese and Rwandan refugees prevent HIV infection.[11] Following the earthquake in El Salvador, an increase in STIs tied to sexual violence and a lack of school activity led to the dispatch of emergency reproductive health kits to decrease the potential spread of HIV/AIDS.[11]

17. HIV/AIDS prevention programmes must place special emphasis on, and direct sufficient resources towards, protecting vulnerable populations and marginalized groups, such as sex workers, mobile populations and injecting drug users. An outreach programme in Hong Kong Special Administrative Region of China and Côte d'Ivoire promoted safer sexual behaviour among sex workers and their clients in full cooperation with sex industry establishments.[24,25] Along the Guatemala-El Salvador border, hundreds of lorry drivers and sex workers have received counselling, training and information materials on HIV prevention.[11] The subregional initiative in Central America and Mexico prioritizes the prevention of HIV and STIs among mobile populations, including sex workers and their clients living in border and port communities.[26] In Belarus and Brazil, legislative change has facilitated the funding and implementation of AIDS education and needle exchange programmes for drug users.[27]

D. Care, support and treatment

18. Broad-based approaches to reversing the course of the epidemic involve the integration of care, support and treatment strategies with prevention. HIV/AIDS has become increasingly treatable thanks to the development of more effective antiretroviral therapies and advances in the management of opportunistic infections. The Government of Brazil instituted a policy of universal access to antiretroviral drugs that decreased mortality considerably.[27] However, antiretroviral therapy remains still unaffordable and inaccessible in most developing countries. Countries such as the Central African Republic, Uganda and Senegal are working towards increased access to care, primarily by negotiating lower prices with pharmaceutical companies.[28]

19. A comprehensive care, support and treatment strategy extends beyond the mere treatment of the disease. It encompasses psychological support to help people cope with the implications of having a life-threatening disease and social support to deal with the economic and social consequences of sickness and death. The justly celebrated Project Hope in Brazil provides home visits and psychological support groups to people living with HIV/AIDS and their families. Likewise, the Sanpatong Home-based Care Project in Thailand provides home care training and support services such as the Thursday Club, a support group for men and women living with HIV/AIDS.[29] The Bambisanani Project in Eastern Cape province of South Africa provides an integrated approach to support people living with HIV/AIDS and their families by placing emphasis on income-generating activities in addition to care and prevention.[30]

20. Voluntary counselling and testing plays a dual role in HIV prevention: by giving clients vital information on how to protect themselves and their partners, and by serving as an entry point of care, treatment and support for people infected with HIV. It

offers people a confidential environment within which to determine their HIV serostatus and deal effectively with its ramifications through the provision of counselling and referral for ongoing emotional support and medical care. The AIDS Information Centre in Uganda, offering same-day HIV testing, counselling and ongoing psychosocial and medical support, presents a good model of an integrated approach.[31]

21. Discrimination and stigmatization of individuals living with HIV is an egregious violation of human rights and hampers prevention by driving the problem underground and blocking access to much-needed services. In the Philippines, the landmark AIDS law prohibits discrimination based on actual or perceived HIV status, bans mandatory HIV testing, strengthens social support and testing services in the country, and insists on confidentiality for people living with HIV/AIDS. Silence and shame about HIV status promote stigmatization of the disease. In Malawi and Zambia, the "Greater Involvement of People Living with HIV/AIDS" project included making HIV/AIDS more visible through personal testimony and positive example, using sensitivity training, prevention campaigns, and workplace counselling to bring AIDS into the open and encourage an effective and humane response.[32]

E. Challenges

22. AIDS is robbing millions of their lives, increasing poverty, reversing human development gains, eroding the ability of Governments to provide and maintain essential services, reducing labour supply and productivity, and undermining social and economic security. AIDS is a global crisis that requires unprecedented resources and political will. Funding from all sources needs to increase significantly and new partners need to be enlisted.[33] Leadership, teamwork and a multisectoral approach are necessary to an effective global AIDS response. Reproductive and sexual health programmes must incorporate HIV prevention strategies that address long-term attitudinal and behavioural changes. Commodities and treatment need to become more widely available and affordable. The challenge now is to build on the newfound commitment and convert it into sustained action, both in the countries and regions already impacted, and in those where the epidemic began later but is gaining momentum.[13]

III. Policies and programmes in reproductive rights and reproductive health

A. Family planning

23. The International Conference on Population and Development and the twenty-first special session of the General Assembly called upon all countries to provide universal access to a full range of safe and reliable family planning methods, and to related reproductive health services, and to assist couples and individuals in making informed decisions freely and responsibly about the number, spacing and timing of their children. The nearly fourfold increase in the proportion of couples using contraception, and the 50 per cent fertility reduction in developing countries in the last 30 years, are in part due to the success of family planning programmes.[7] However, still substantial proportions of women in every country, and more than 50 per cent in some, stated in surveys that their last birth had been unwanted or mistimed. Indeed, if women are to succeed in controlling their childbearing, they need access to effective methods of birth control. Beside contraception, women's control over childbearing requires improvements in education level, the age at which women marry, their role within the family, their likelihood of being subjected to domestic violence and the degree to which husbands or partners support their goals in respect of family size and contraceptive use.[34]

24. By making high-quality family planning services more widely available, countries and communities can help reduce unplanned pregnancies, many of which result in unsafe abortion and take a large toll on women's health. The ACCESS project of the Centre for Development and Population Activities in Nigeria works with 10 women-focused organizations in several States to provide community-based family planning and reproductive health services. In Bangladesh, reproductive health, including family planning, is made part of the essential health services package. In an effort to overcome barriers to contraceptive use, the Key Social Marketing Project in Pakistan built demand for contraception and access to reproductive health services through television, distribution of audiocassettes, community chat groups, and private sector provider training.[5] In the Islamic Republic of Iran, religious leaders, merchants and teachers received

training in order to remove cultural barriers to the use of reproductive health and family planning services.[25]

25. A woman's ability to plan her reproductive life depends on having access to the full range of contraceptive methods. Important progress has been made, but there remains a huge challenge of ensuring availability of commodities. To address this problem, in September 2000, a global strategy for reproductive health commodity security (RHCS) was launched at the initiation of UNFPA.[23] In response to the UNFPA RHCS Global Call to Action, non-governmental organizations, Governments, private foundations, and bilateral and multilateral partners met in May 2001 in Istanbul to develop concrete and immediate actions in advocacy, national capacity-building, financing, and donor contributions to secure reproductive health supplies.[35]

26. Strong government action and the lifting of legislative barriers are needed to allow couples full access to family planning. Portugal amended its Constitution to make the provision of family planning a State obligation. The Government of Mexico has begun providing contraceptive services and methods free of charge, thereby meeting the contraceptive needs of the majority of the population. In Ethiopia, a 1998 Proclamation repealed the Penal Code provision prohibiting the advertisement and promotion of contraceptive methods. France became the first country to permit the sale of emergency contraceptives over the counter. Japan took the vital step of preventing unwanted pregnancies by lifting the ban on oral contraceptives.[25]

27. Most countries still have some way to go to achieve the goal of reproductive health for all their citizens. Special efforts are needed to continue to improve information about and access to family planning among young people, ethnic minorities, rural dwellers and other marginalized groups. Official and informal barriers to contraceptive access, such as spousal authorization, age restriction and marital status, need to be lifted.[36] Stakeholders need to continue the dynamic process of partnership, solidarity and commitment to action to ensure the availability of reproductive health supplies. To save lives and protect the health of men, women and children, family planning programmes need to be fully integrated into reproductive health programmes to expand their reach, improve quality, and provide a full range of services to men and women.[7]

B. Maternal mortality and morbidity

28. An estimated 515,000 women of childbearing age die annually owing to complications arising from pregnancy and childbirth.[37] The lack of care during pregnancy and childbirth contributes to their deaths and compromises the health and survival of the infants and children whom they leave behind. Most of these deaths could be avoided if adequate care were available and if the health and nutrition status of adolescent girls, who run a high risk of maternal mortality, were improved. The International Conference on Population and Development, the twenty-first special session of the General Assembly, the Fourth World Conference on Women, and the Safe Motherhood Technical Consultation in Colombo, Sri Lanka, focused attention on reducing maternal mortality in the context of human rights by advocating the empowerment of women; delaying marriage and first birth; ensuring skilled attendance at delivery; improving access to quality maternal health services; preventing unwanted pregnancy; and addressing unsafe abortion.[38] More recently, in 2001 the Bamako Declaration expressed commitment of national and international key players to accelerating actions to significantly reduce maternal and neonatal mortality in West and Central Africa in the framework of reproductive rights.[39]

29. Multisectoral approaches, involving, in addition to measures taken in the health sector, actions in the fields of education, legislation and advocacy, are essential for the reduction of maternal mortality and morbidity. Evaluations in countries such as Tunisia, Sri Lanka, Kerala State in India, Cuba, China and the former Soviet Union established that maternal morbidity and mortality could be reduced through the synergistic effect of combined interventions. These include: education for all; universal access to basic health services and nutrition before, during and after childbirth; access to family planning services; attendance at birth by trained birth attendants; and access to good quality care in case of complications. A rural emergency relief programme in Uganda helped reduce the number of maternal deaths and increase the number of supervised deliveries via a referral system for essential obstetric care, linking traditional birth attendants, health clinics and hospitals.[40] Gains in countries such as Malaysia and Sri Lanka were achieved by making maternity care a core area in their health service reforms.[41]

30. Women attended by a professional during childbirth are more likely to avoid serious complications and receive treatment early. Skilled attendants need to be supported with adequate supplies and equipment, regulations that permit them to carry out necessary procedures, and supportive supervision and monitoring. Skilled birth attendance and access to essential obstetric care have risen in Bangladesh as a result of training doctors in obstetric care and anaesthesiology. In addition, maternal and child welfare centres were upgraded to provide comprehensive services including essential obstetric care. Similarly, doctors and nurses in 13 provinces of Morocco have been trained in life-saving skills, and five health facilities have been upgraded with necessary surgical and sterilization instruments enabling health workers to administer antibiotics and anti-convulsants, assist in delivery, and perform caesarean sections, and blood transfusions when needed.[42] In Ghana, the training of midwives in life-saving skills, and giving them a central role in the delivery of services, resulted in the decline of referrals to higher levels in the health system.[43] Many other countries, including Afghanistan, Honduras, the Islamic Republic of Iran, Mauritania, Rwanda and Yemen are training physicians to strengthen their skills and capacity in essential obstetric care.[44]

31. The challenge with respect to maternal care is to reorient programmes on priority interventions, and to mobilize sufficient resources for their implementation. More resources have been put into antenatal care than into managing complications during delivery and immediate post-partum care.[45] Yet the vast majority of complications and deaths arise during and immediately after delivery, because of sudden, unexpected complications, and from unsafe abortions. Health professionals — midwives, obstetricians, public-health physicians — have a central role to play in the implementation of priority interventions such as providing skilled attendants with essential midwifery skills, and with the needed back-up of referral, logistics, managerial and supervisory support.[38]

C. Sexually transmitted infections

32. Worldwide, the high incidence of STIs is a serious public-health concern. Six out of 10 women in many countries surveyed had a sexually transmitted infection. Cultural factors and anatomical differences make women more vulnerable to STIs than men. As a result, they are exposed to the risk of infertility, cervical cancer, spontaneous abortions, congenital infections and other serious health problems.[36] Investing in the prevention of STIs is highly cost-effective, particularly when considering the benefits of reducing HIV transmission. However, effective prevention and care of STIs are hindered by the fact that many cases are asymptomatic; individuals are unwilling to seek care or to notify partners; there is a lack of availability or suitability of STI services; individuals are ignorant of STIs — their causes, symptoms, cures and possible consequences; and the prescribed treatment is substandard.[46] In addition, many STI and HIV/AIDS prevention campaigns are based on condom negotiation between partners that relies on the mistaken assumption of equality of power between men and women. Women may be unable to insist on condom use as a STI prevention measure in part because of their lower social status and financial dependence on men.[40]

33. As indicated at the International Conference on Population and Development and the twenty-first special session of the General Assembly, reproductive health programmes play a vital role in reducing STIs, including HIV/AIDS. Mozambique and Burkina Faso have added the prevention and management of STIs, including HIV/AIDS, to family planning services.[7] In the Philippines, the Women's Health Care Foundation provides access to reproductive health services that include referrals for STI/HIV testing as well as a telephone hotline to answer questions on STIs and sexuality.[43]

34. Scientists have recently focused on developing female contraceptive technologies including the female condom and vaginal microbicides, to prevent the spread of STIs. UNFPA procured the supply of female condoms to 27 countries including Angola, Mongolia, South Africa, and Zimbabwe.[21] In Lesotho, the Japan Trust Fund supported family planning associations to promote the female condom.[47] In Thailand, sex workers experienced a 34 per cent decrease in the number of STIs as a result of using the female condom. The same study also found that sex workers who had access to both the female and male condom were less likely to have unprotected sex than women who had access only to male condoms.[27] Acceptability studies in seven countries, including Brazil, India, Thailand, Uganda and Zimbabwe, have confirmed the urgent need women

feel for a prevention method they can control. Interest in microbicides has grown steadily as evidenced by the formation of the Alliance of Microbicide Development, the establishment of the Global Microbicide Project funded by the Gates Foundation in 2000, and the convening of the first major scientific conference on microbicides held in 2000.[48,49]

35. STI control, including STI prevention and effective case management, is an essential component of HIV prevention and control programmes.[50] This fact is increasingly being recognized by Governments. The Government of Zimbabwe is combating a severe HIV/AIDS epidemic in the eastern border town of Mutare by emphasis on the treatment of STIs and the tracing of patient's contacts, HIV peer education, outreach to commercial sex workers, distribution of condoms, and a home-based care programme.[51] In Uganda, the Government launched a national campaign to treat STIs, stressing their key role in the spread of HIV/AIDS.

D. Adolescent reproductive and sexual health

36. The International Conference on Population and Development was pivotal in recognizing the needs of adolescents, and the importance of promoting their reproductive and sexual health as a means of ensuring their overall well-being. During the transition period between adolescence and adulthood, young people are subjected to social pressures and peer expectations that result in risky behaviour. Limited knowledge about reproductive and sexual health issues makes adolescents vulnerable to STIs, including HIV/AIDS, unwanted pregnancies, sexual exploitation and violence. Half of all new HIV infections, over 7,000 daily, are occurring among young people aged 15-24 years.[52] These numbers highlight the importance of providing culturally sensitive and appropriate sexual health education and services to young people.

37. Information, education and communication are identified in the Programme of Action of the International Conference on Population and Development as the best means of motivating changes in behaviour and assisting young people in making informed and responsible decisions about their reproductive and sexual health. Interpersonal communication and counselling skills are fundamental to addressing the sensitive issues of family planning and prevention of STIs, including HIV/AIDS. In Sri Lanka, a survey found that only half of 15-29-year-olds were aware that condoms protected against HIV/AIDS and other diseases. The response was a massive campaign to provide more than 100,000 young people with reproductive and sexual health information and 32,000 have received specific counselling. Information, education and communication strategies in Mongolia involved the discussion of dating, family relationships and reproductive health in *Love*, the most popular magazine among adolescents. The "In-and-Out of School Youth" Project in the Sudan focuses on the thousands of young people forced from their homes owing to armed conflict, and provides them with education on reproductive health issues through a mobile exhibit at youth camps.[25] Within the context of formal education, the Palestinian Authority integrated reproductive health and gender issues into school curricula, adult education, teacher training, and youth education programmes.[53]

38. In recognition of the diversity of adolescents and youth and their varied life circumstances, different approaches and communication strategies taking advantage of multiple entry points are required to reach young people. "Scenarios from the Sahel", currently being implemented in Senegal, Mali and Burkina Faso, is a series of short educational films on reproductive and sexual issues by well-known African film directors, based on winning themes submitted by young people. In a similar vein, a youth theatre group in Vanuatu performed plays on various reproductive health subjects, including the transmission of STIs, that led to an increase in the number of young people visiting health clinics.[53]

39. In addition to information, education and communication strategies, preventive interventions include the provision of adolescent-friendly services to enable those adolescents who are sexually active to engage in healthy and responsible behaviour. Eleven health clinics in Kenya were converted to "youth-friendly" facilities by expanding working hours and providing separate rooms for youth counselling. Angola established youth-friendly health centres and trained peer counsellors, resulting in the seeking of guidance on prenatal care, family planning and the diagnosis of STIs by thousands of adolescents. A national network of health and family planning centres in Ecuador reorganized clinic layouts to give adolescents their own space, expanded hours to

accommodate school and work schedules, and set special, lower consultation fees for adolescents.[5] A youth information project in Algeria incorporates training of health centre service providers on dealing with young people and providing them with the information and care they need to protect their reproductive health.[53] In Botswana, youth-friendly health care was incorporated into multi-purpose youth centres which also provide information and counselling to enable young people to make responsible decisions about their sexual behaviour.[36]

40. Reproductive and sexual health remains a sensitive issue for many parents, teachers and providers. In addition, in many countries, legislation and policies prevent adolescents from receiving reproductive and sexual health education and services. Youth-friendly services are limited in number and scope and need to involve adolescents in all aspects of programming if they are to be utilized and valued. Furthermore, information, education and communication activities are often disconnected from service delivery, and educators and providers need to integrate these components in order to be more effective in meeting the needs of adolescents. Training health providers and educators on youth-friendly services is one approach to bridging the gap between information exchange and service delivery.[5]

E. Gender equality and women's empowerment

41. The International Conference on Population and Development, the twenty-first special session of the General Assembly, and the Fourth World Conference on Women stressed that gender equality is a human rights concern, and that empowering women ensures the development of a sustainable and equitable society.[40] Yet, of the more than 110 million children not in school, two thirds are girls, and nearly two thirds of the 875 million illiterate adults are women. Girls' education is essential to sustainable human development and increases the ability of girls to protect themselves from HIV/AIDS and other diseases, sexual violence, economic exploitation, poverty and hunger. Girls' education supports greater participation of women in leadership and decision-making roles and ensures future equity. In 2000, the United Nations Girls' Education Initiative was launched with the goal of securing quality education for all girls everywhere. Many countries, including Egypt, Nepal and Malawi, have committed to the Initiative and have put in place programmes to implement it.[54]

42. Women's economic dependence and, in many societies, their lack of rights to property or access to finance, have long crippled their ability to take care of themselves and their families. Poverty is particularly destructive of women's health, including their reproductive and sexual health. The majority of the world's absolute poor are women.[40] In addition, women continue to be grossly underrepresented in positions of power and decision-making. This contributes to the exclusion of their perspectives from reproductive policies and programmes. To address this problem, the Dominican Republic and Peru have created institutional mechanisms such as women's ministries or women's bureaux, and training for women's political leadership and participation in the legislative processes has taken place in Bolivia, Ecuador, El Salvador, the Dominican Republic and Venezuela.[43]

43. Because men hold the power to influence societal thinking in most parts of the world, achieving gender equality, equity and women's empowerment will require their support.[35] They can play an important role in safeguarding the reproductive and sexual health of the women in their lives, as shown in Pakistan, where teams of community educators focused on men in order to promote family planning through home visits, distribution of contraceptives and referrals to clinics. Not only were the men receptive to family planning, but they encouraged women educators to speak to their wives.[40] Likewise, a mass media campaign in Uganda resulted in improved male involvement in family planning and maternal health.[25]

44. Violence against women and girls is firmly rooted in the low status of women. The Beijing Platform for Action[55] articulated that "in all societies, to a greater or lesser degree, women and girls are subjected to physical, sexual and psychological abuse that cuts across lines of income, class and culture ... Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms" (para. 112). This violence includes a wide range of violations of women's human rights, including trafficking in women and girls, rape, wife abuse, sexual abuse of children, and harmful practices and traditions that irreparably damage girls' and women's reproductive and sexual health, exposing them to STIs, including HIV/AIDS. It occurs in a

broader context of gender-based discrimination with regard to access to education, resources and decision-making power in private and public life.[56]

45. Countries have begun to address the difficult issues of gender-based violence that often exist in a culture of silence and denial in respect of the seriousness of the health consequences of abuse at every level of society. In Morocco, a research project with the Ministry of Justice seeks to determine the incidence of domestic violence and to identify underlying trends and the most vulnerable groups. Results will be used to sensitize decision makers for the purpose of concerted actions through a community response and referral system. Innovative male sensitization workshops on gender-based violence were held in Kenya for police officers, chiefs and assistant chiefs.[40] Many countries have recently adopted domestic violence legislation, including Belgium, Bermuda, the Dominican Republic, Honduras, Mexico, South Africa and Venezuela.[43] A national plan of action on the elimination of violence against women was initiated in Indonesia in 2000.[25]

46. The practice of female genital mutilation breaches the human right to health and bodily integrity. Female genital mutilation harms the reproductive and sexual health of women, and can contribute to the spread of HIV/AIDS by tearing scarred vaginal tissue.[57] In Africa, efforts to eliminate female genital mutilation range from laws criminalizing the procedure to education and outreach programmes. Burkina Faso, the Central African Republic, Côte d'Ivoire, Djibouti, Ghana, Guinea, Senegal, Togo and the United Republic of Tanzania have all banned the procedure.[20] However, legislation alone is not enough: social attitudes and beliefs need to be addressed. In Uganda's Kapchorwa district, members of the Sabiny Elders' Association and clan leaders were sensitized on the harmful effects of female genital mutilation and, in turn, educated the community and proposed replacing the practice with symbolic gift-giving and other festivities. This culturally sensitive approach is being replicated in Mali and elsewhere.

47. Sexual exploitation and trafficking in children are a global problem that involves tens of millions of children in the sex market and the introduction of 2 million girls aged 5-15 years into the trade annually. The globalization process has severely impacted the economic situation of many women in Asia who are often enticed into the sex trade to escape poverty in their homeland. In response to the growing problem, the Cambodian National Council for Children has launched a national five-year plan against sexual exploitation and trafficking. In Benin, the Project on Children in Need of Special Protection raises awareness about trafficking and exploitation, and the hazards faced by children who are forced into it.[58] To combat this problem, the United Nations Children's Fund (UNICEF) in Nepal supported the development of paralegal and community surveillance system in 14 districts.[59]

IV. Partnerships

48. To advance goals of the International Conference on Population and Development, broad alliances have been built to promote reproductive health. The International Partnership against HIV/AIDS in Africa was formed to provide financial, technical and management support to strengthen national AIDS councils in countries such as Botswana, Mozambique, Nigeria, the United Republic of Tanzania and Zimbabwe.[60] A five-year project is being carried out by the African Youth Alliance, with technical support from UNFPA and a $57 million grant from the Bill and Melinda Gates Foundation, to strengthen efforts to protect young people from HIV/AIDS in four African countries.[25] The United Nations Foundation awarded $23 million to several partners, including UNFPA, to support global programmes in reproductive health and prevent HIV infection among young people.[53] The Drug Access Initiative of seven of the world's leading pharmaceutical companies is dedicated to increased access to HIV treatment and care. In particular, Bristol-Myers Squibb pledged an unprecedented $100 million over five years to address the HIV/AIDS epidemic in the countries of South Africa, Namibia, Lesotho, Swaziland and Botswana.[61] UNAIDS has teamed up with MTV to promote HIV/AIDS awareness among its 1 billion young viewers around the world.[62]

49. Networks of civil society organizations have become increasingly important since the International Conference on Population and Development. The Reproductive Health Initiative is an innovative partnership between the European Commission, UNFPA and international and local non-governmental organizations to improve reproductive health information and services in seven Asian countries.[25] The International Planned Parenthood Federation,

Western Hemisphere Region, initiated a South-North Partnership that seeks to improve communication and exchange experiences, strategies and reproductive and sexual health programme models between Northern and Southern non-governmental organizations.[63]

50. Inter-agency collaborations within the United Nations system have also been beneficial in promoting collective action to achieve the goals of the Programme of Action of the International Conference on Population and Development. UNICEF, UNFPA and the World Health Organization (WHO) are collaborating on a project to fulfil the development and participation rights of adolescent girls in 17 countries in Asia, Africa and the Middle East.[64] These same organizations established a Coordinating Committee on Health to enhance partnership and they, together with UNAIDS, launched a global inter-agency initiative to reduce mother-to-child transmission of HIV/AIDS. To improve quality of care, WHO and UNFPA collaborated on the publication of a new reference manual that contains medical eligibility criteria for different types of contraceptives, helping women to determine which type is the safest and most appropriate for them.[25]

51. Partnership has emerged as a basic element to support and advance the Programme of Action implementation process. Numerous constraints, however, often frustrate collaboration: insufficient financial resources, weak commitment to the partnership, inadequate institutional capacity and protection of vested interests. For institutions of civil society to engage more actively and effectively as reproductive health partners, financial and technical assistance for capacity-building is essential. Governments, non-governmental organizations, the private sector, international organizations and others should significantly increase their efforts to identify areas of cooperation and promote innovative modalities to achieve programme synergy, particularly with respect to the provision of reproductive health services.[65]

V. Conclusions

52. This review of policy and programme activities reveals a significant level of progress with respect to improving reproductive rights and reproductive health, particularly in connection with HIV/AIDS. Efforts that are rooted in human rights continue to build on the momentum created at the International Conference on Population and Development and the twenty-first special session of the General Assembly. Progress has been made in promoting and implementing a more comprehensive approach to reproductive health. A scaled-up global response to HIV/AIDS is focusing on the full spectrum of responses, including political commitment, prevention, care and support. Activities to integrate STIs/HIV/AIDS prevention into reproductive and sexual health programmes have intensified. Family planning programmes are increasing the availability of contraceptives and services, creating greater opportunities for individual choice and decision-making. Countries are striving to reduce maternal deaths by upgrading health-care facilities so as to make essential and obstetric care more widely available, training health service providers, providing transportation for women, and mobilizing communities to fully use the services. Adolescent reproductive and sexual health programmes have employed advocacy, information, education and communication, and youth-friendly services to reach young people and help them stay healthy. Greater attention has been paid to the empowerment of women as a means to improve their reproductive and sexual health. Partnerships have been formed to capitalize on strengths of individual organizations, institutions, companies and Governments. These global alliances will help ensure that women, men and families have the information, services and supplies that they need to make informed, responsible and free choices about their reproductive and sexual health, in fulfilment of their human rights.

Notes

[1] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[2] See General Assembly resolution S-21/2, annex; and United Nations Population Fund, *The State of World Population, 2000* (New York, UNFPA, 2000).

[3] General Assembly resolution S-26/2, annex.

[4] See UNFPA, *Ensuring Reproductive Rights and Implementing Sexual and Reproductive Health Programmes Including Women's Empowerment, Male Involvement, and Human Rights* (New York, UNFPA, 1998).

[5] See Family Care International, *Meeting the Cairo Challenge: Progress in Sexual and Reproductive Health* (New York, 1999).

[6] See UNFPA, "Interregional project on quality of care, Concept Paper", 2001.

[7] See UNFPA, *The State of World Population, 1999* (New York, UNFPA, 1999).

[8] See UNFPA, *A Focus on Population and Human Rights* (New York, UNFPA, 1998).

[9] See United Nations Development Group, "Guidance note on HIV/AIDS", August 2001.

[10] See UNFPA, "HIV prevention now", programme brief, No. 1, 2001.

[11] See UNFPA, *Preventing Infection, Promoting Reproductive Health: UNFPA's Response to HIV/AIDS* (United Nations publication, Sales No. E.01.III.H.4).

[12] See UNAIDS, "AIDS epidemic update: December 2000", 2000.

[13] See UNAIDS, "AIDS epidemic update: December 2001", 2001.

[14] See Inter-Parliamentary Union (IPU) press release entitled "Resolutions on HIV/AIDS, children and the situation in the Arab Occupied Territories adopted by the 106th Inter-Parliamentary Conference", Ouagadougou, 14 September 2001, No. 7.

[15] See UNAIDS, "AIDS education: a battle against ignorance", fact sheet of the special session of the General Assembly on HIV/AIDS, 2001.

[16] See UNAIDS, "Preventing HIV/AIDS", fact sheet of the special session of the General Assembly on HIV/AIDS, 2001.

[17] See UNAIDS, *Condom Social Marketing: Selected Case Studies*, UNAIDS Best Practice Collection (Geneva, 2000).

[18] See report by the Executive Director, Programme Coordinating Board, UNAIDS, May 2001.

[19] See UNAIDS, *The Impact of Voluntary Counselling and Testing: A Global Review of the Benefits and Challenges*, UNAIDS Best Practice Collection, 2001.

[20] See United Nations Children's Fund, *The Progress of Nations* (New York, UNICEF, 2000).

[21] See report of the Executive Director of UNFPA (DP/FPA/2001/9) entitled "UNFPA proposed contribution to the United Nations system strategic plan for HIV/AIDS for 2001-2005", 27 April 2001.

[22] See UNICEF web site (http://www.unicef.org/programme/hiv/focus/youth/youth.html), 2001.

[23] See UNAIDS, *Gender and HIV/AIDS: Taking Stock of Research and Programmes*, UNAIDS Best Practice Collection (Geneva, 1999).

[24] See UNAIDS, "Summary booklet of best practices", issue No. 1, 1999.

[25] See UNFPA, *Annual Report, 2000* (New York, 2000).

[26] See UNAIDS, *The UNAIDS report, 1999* (Geneva, 1999).

[27] See UNAIDS, *Report on the Global HIV/AIDS Epidemic* (Geneva, June 2000).

[28] See report by the Executive Director, Programme Coordinating Board, UNAIDS, December 2000.

[29] See UNAIDS, *Comfort and Hope, Six Case Studies on Mobilizing Family and Community Care for and by People with HIV/AIDS*, UNAIDS Case Study (Geneva, 1999).

[30] See UNAIDS, *Reaching out, Scaling Up*, Best Practice Collection (Geneva, 2001).

[31] See UNAIDS, *Knowledge Is Power: Voluntary HIV Counselling and Testing in Uganda*, UNAIDS Case Study (Geneva, 1999).

[32] See UNAIDS, *The UNAIDS Report* (Geneva, 1999).

[33] See round table 4: International funding and cooperation, 2001.

[34] See UNFPA, *Hopes and Realities: Closing the Gap between Women's Aspirations and their Reproductive Experiences* (New York, 1999).

[35] Meeting on Moving Forward Together from Istanbul to Secure Reproductive Health Supplies, Istanbul, 2001.

[36] See UNFPA, *The Right to Choose: Reproductive Rights and Reproductive Health* (New York, 2000).

[37] See "Maternal mortality in 1995: estimates developed by WHO, UNICEF, UNFPA" (WHO/RHR/01.9), 2001.

[38] See Family Care International, *The Safe Motherhood Action Agenda: Priorities for the Next Decade* (New York, 1998).

[39] UNFPA, "Making Safe Motherhood a Reality", annual report, 2000, to Columbia University, 2001.

[40] See UNFPA, *Working to Empower Women, UNFPA's Experience in Implementing the Beijing Platform for Action* (United Nations publication, Sales No. E.00.III.H.2).

[41] See E. Goodburn and D. Campbell, "Reducing maternal mortality in the developing world: sector-wide approaches may be the key", *British Medical Journal*, vol. 322 (2001), pp. 917-920.

[42] See UNFPA, *Future Generations Ready for the World* (New York, 2001).

[43] UNFPA, *The State of World Population, 2000* (New York, UNFPA, 2000).

[44] See UNFPA, *Maternal Mortality Update 1998-1999: A Report on UNFPA Support for Maternal Mortality Prevention* (New York, 2001).

[45] See World Bank, *Safe Motherhood and The World Bank: Lessons from Ten Years of Experience* (Washington, D.C., June 1999).

[46] See UNAIDS, "The public health approach to STI control", UNAIDS technical update, 1998.

[47] See International Planned Parenthood Federation, *Annual Report, 2000* (London, 2000).

[48] See Population Council, Inc., and International Family Health, *The Case for Microbicides: A Global Priority* (New York and London, 2000).

[49] Consortium for Industrial Collaboration in Contraceptive Research meeting, Washington, D.C., April 2000.

[50] See UNAIDS and WHO, *Consultation on STI Interventions for Preventing HIV: What Is the Evidence?* UNAIDS Best Practice Collection (Geneva, 2000).

[51] Center for Reproductive Law and Policy, *Reproductive Rights 2000: Moving Forward* (New York and Washington, D.C., 2001).

[52] See UNAIDS, "Preventing HIV/AIDS among young people", fact sheet of the special session of the General Assembly on HIV/AIDS, 2001.

[53] See UNFPA, *Annual Report, 1999* (New York, 1999).

[54] UNICEF, "United Nations Girls' Education Initiative", 2000.

[55] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

[56] See UNFPA, *Violence against Girls and Women: A Public Health Priority* (United Nations publication, Sales No. E.99.III.H.3).

[57] See UNFPA, *Women's Empowerment and Reproductive Health: Links throughout the Life Cycle* (United Nations publication, Sales No. E.00.III.H.3).

[58] See "Child protection, child trafficking": UNICEF web site (http://www.unicef.org/programme/cprotection/focus/trafficking/measures.htm), 2001.

[59] See "Implementation of the Beijing Platform for Action: violence against women": UNICEF web site (http://www.unicef.org/programme/gpp/new/beijing5/index.htm), 2001.

[60] See UNAIDS, "The International Partnership against AIDS in Africa", fact sheet of the special session of the General Assembly on HIV/AIDS, 2001.

[61] See UNAIDS, "Accelerating access to HIV/AIDS care, treatment and support", progress report, September 2001.

[62] See UNAIDS, "The United Nations at work: the fight against AIDS", fact sheet of the special session of the General Assembly on HIV/AIDS, 2001.

[63] See International Planned Parenthood Federation, "South-North Partnerships", *Newsletter for Donors*, vol. 2, issue No. 2 (April 2000).

[64] See "Meeting the participation and development rights of adolescent girls", concept paper, 2000.

[65] See UNFPA, Hague Forum background paper entitled "A five-year review of progress towards the implementation of the Programme of Action of the International Conference on Population and Development", chap. V entitled "Building partnerships", 1999.